



**AUBURN UNIVERSITY
AT MONTGOMERY**

**CENTER FOR
DISABILITY SERVICES**

Specific Guidelines for Mental Health, Mobility, Sensory, and Other Health Conditions

The Center for Disability Services (CDS) provides academic services and accommodations for students with diagnosed disabilities. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In order to receive academic accommodations, the student must submit comprehensive documentation describing the current functional limitations that impact the student in an academic setting. Documentation serves as the basis for decision-making about a student's needs for accommodations in a challenging and competitive academic environment.

Documentation of a high quality is relevant, useful, and thorough. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

GENERAL GUIDELINES FOR PROVIDING DOCUMENTATION

- Documentation is provided by a licensed or otherwise properly credentialed professional who has appropriate and comprehensive training, relevant experience, and no personal relationship with the individual being evaluated. A good match between the credentials of the individual making the diagnosis and the condition being reported is expected (e.g., an orthopedic limitation might be documented by a physician, but not a licensed psychologist).
- Documentation includes a clear diagnostic statement that describes how the condition was diagnosed, provides information on the functional impact, and details the typical progression or prognosis of the condition. The documentation should include the diagnostic criteria, evaluation methods, procedures, tests dates of administration, as well as a clinical narrative, observation, and specific results. Diagnostic tests should be based on adult norms.
- Documentation should be relatively recent in order to provide an accurate description of current functioning. Because some conditions are permanent or non-varying, guidelines will differ from case to case. Contact the Center for Disability Services at 334-244-3631 to speak with a CDS staff member to determine how current the documentation should be for your particular situation.
- Documentation should address the major life activities (i.e., caring for oneself, performing manual tasks, seeing, hearing, learning, walking, reading, concentrating, thinking etc.) affected by the disability and how those functional limitations impact the student in an academic setting. Documentation that does not address an individual's current level of functioning or need for accommodation(s) may warrant the need for a new evaluation.

In lieu of the attached form, other types of documentation may be sent that thoroughly address the questions below. Failure to address the following questions could delay the accommodation process.

Specific Guidelines for Mental Health, Mobility, Sensory, and Other Health Conditions

Student Name (First, Middle, Last): _____

Date of Birth: _____ AUM Email: _____@aum.edu

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

To Be Completed by the Health Care Professional

1. What is the diagnosis, date of diagnosis, and last contact with the student?

2. List co-morbid diagnoses or other health issues that might complicate this condition.

3. Severity of the disability: Negligible Moderate Severe

4. Duration of the disability: Six Months or Less Greater than Six Months

5. Describe the progression of this disability, if applicable.

6. Please describe the student's symptoms relating to this diagnosis.

7. Major Life Activities Assessment: Please review major life activities listed below and indicate the severity the impairment(s) places on each activity.

| Life Activity | Negligible | Moderate | Substantial | Unknown |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Walking * | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seeing * | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing* | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Talking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Caring for Oneself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Performing Manual Tasks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Writing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Learning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thinking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Concentrating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Memorizing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interacting with Others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

***Walking Limitation:**

- Is unable to walk 200 feet without stopping to rest.
- Is unable to walk without use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.

***Seeing Limitation:**

Visual Acuity _____
Assistive devices used by the student _____

*** Hearing Limitation:**

(Include an audiogram)

Needs a sign language interpreter
Assistive devices used by the student _____

8. Describe any ongoing medical or therapeutic treatment, and indicate how the treatment might affect the student academically.

9. List current medication(s), impact, and adverse side effects.

10. Describe the student's functional limitations and how they could affect the student in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to focus for a sustained period of time).

11. If accommodations are recommended, provide a rationale as to why these accommodations are warranted based upon the student's functional limitations. For example, if a note taker is suggested, state the reasons for this request related to the student's functional limitation.

Healthcare Provider Information

Name: _____ Specialty: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____

E-Mail: _____ License or Certification #: _____

With my signature, I certify that the above information is true and documented as part of the patient's medical record.

Provider Signature: _____ Date: _____

This form or other submitted documentation may be released to the student at his or her request.

Please mail or fax this form or other documentation to:

AUM
Center for Disability Services
Auburn University at Montgomery
PO Box 244023
Montgomery, AL 36124-4023

Phone: 334-244-3631

Fax: 334-244-3907